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Perceptions of Needs, Assets, and Priorities Among Black Men Who Have Sex With Men With HIV: Community-Driven Actions and Impacts of a Participatory Photovoice Process

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Abstract

Black men who have sex with men (MSM) with HIV experience significant health inequities and poorer health outcomes compared with other persons with HIV. The primary aims of this study were to describe the needs, assets, and priorities of Black MSM with HIV who live in the Southern United States and identify actions to improve their health using photovoice. Photovoice, a participatory, collaborative research methodology that combines documentary photography with group discussion, was conducted with six Black MSM with HIV. From the photographs and discussions, primary themes of discrimination and rejection, lack of mental health services, coping strategies to reduce stress, sources of acceptance and support, and future aspirations emerged. After the photographs were taken and discussed, the participants hosted a photo exhibition and community forum for the public. Here, 37 community attendees and influential advocates collaborated with the participants to identify 12 actions to address the men's identified needs, assets, and priorities. These included making structural changes in the legal and medical systems, encouraging dialogue to eliminate multiple forms of stigma and racism, and advocating for comprehensive care for persons with HIV. As a secondary aim, the impacts of photovoice were assessed. Participants reported enjoying photovoice and found it meaningful. Results suggest that in addition to cultivating rich community-based knowledge, photovoice may result in positive changes for Black MSM with HIV.

Keywords

photovoice, qualitative research, HIV, Black/African American, men who have sex with men (MSM), sexual and gender minorities

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Black or African American (hereafter referred to as Black) communities, particularly Black gay, bisexual, and other men who have sex with men (collectively referred to as MSM), are disproportionately affected by HIV (Centers for Disease Control and Prevention [CDC], 2016; Hall, Byers, Ling, & Espinoza, 2007; Hanna, Selik, Tang, & Gange, 2012; Reif et al., 2014). Black MSM have the highest HIV infection and prevalence rates in the United States (Hess, Hu, Lansky, Mermin, & Hall, 2017), are often diagnosed with HIV late (Mannheimer et al., 2014), experience significant delays in receiving HIV

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treatment and care (Millett et al., 2012; Singh et al., 2014; Whiteside et al., 2014), are less likely to achieve viral suppression (Singh et al., 2014), and have the shortest survival rates (Hall et al., 2007). The death rate among Black MSM with HIV (15.3 per 1,000 persons living with HIV [PLWH]) is higher than the rate among their White and Latino MSM peers, 15.1 and 9.4 per 1,000 PLWH, respectively (Siddiqi, Hu, & Hall, 2015). Improvements are needed at all stages of the HIV care continuum: diagnosis of HIV infection, access and linkage to care, and receipt of and adherence to antiretroviral therapy to achieve viral suppression.

Intrapersonal, interpersonal, community, health-care system, and health-care policy factors, all influence the HIV care continuum (Mugavero, Amico, Horn, & Thompson, 2013). Plausible explanations for these significant HIV care continuum inequities¹ experienced by Black MSM include systemic poverty, lack of health insurance, housing instability, mental health, substance abuse, food insecurity, inadequate access to culturally competent services, incarceration, lack of social support, racism, discrimination, and stigma (Aidala et al., 2016; Arnold, Rebchook, & Kegeles, 2014; Levy et al., 2014; Nieblas, Hughes, Andrews, & Relf, 2015; Rothman et al., 2012; Sumari-De Boer, Sprangers, Prins, & Nieuwkerk, 2012; Toth, Messer, & Quinlivan, 2013; Weiser et al., 2009).

Researchers have described previous work on Black MSM with HIV to be insufficient and inadequate, and new research that is able to comprehensively study these processes is critical for achieving equitable improvements in care and health outcomes across the HIV continuum (Eaton et al., 2018; Hightow-Weidman et al., 2017). Most of the existing research has relied on quantitative methods, which are limited in their ability to describe the intricate contexts that shape the lived experiences of Black MSM with or without HIV (Millett et al., 2012; Wilson et al., 2016). There has been limited success in uncovering and explaining the complexities of the experiences of Black MSM with HIV, including barriers and stigma experienced at all socio-ecological levels (Eaton et al., 2018; Hightow-Weidman et al., 2017). As such, researchers have called for more qualitative research to contextualize and address stigma, racism, and other stereotypes affecting Black MSM (Wilson et al., 2016). In particular, qualitative methods that engage Black MSM and their social networks will enrich the exploration of the intersectionality and layered stigma experienced by Black MSM and these have been described as essential for further understanding and addressing the needs of this community (Mays, Cochran, & Zamudio, 2004; Wilson et al., 2016). This study serves to amplify the voices of Black MSM with HIV through the photovoice process

by determining their concerns and priorities and the initiatives that need to occur.

There have been calls for greater emphasis to address the HIV inequities in the Southern United States (Reif, Safley, McAllaster, Wilson, & Whetten, 2017), where communities are disproportionately affected by HIV compared with communities in other parts of the United States. Forty-four percent of PLWH in the United States reside in the Southern states (i.e., Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; CDC, 2015); yet, they only comprise 37% of the U.S. population (U.S. Census Bureau, 2015). Seven of the 10 states with the highest HIV death rate are in the Southern United States (Siddiqi et al., 2015). Among Black MSM, more than 60% diagnosed with HIV were living in the South (CDC, 2015). Reducing the impact of HIV in the South was identified as a major priority by the White House as described in the National HIV/AIDS Strategy: Updated for 2020 (White House Office of National AIDS Policy, 2015).

The primary aims of this study were to describe the needs, assets, and priorities of Black MSM with HIV who live in the Southern United States and identify actions to improve their health by addressing their needs and priorities using photovoice, a qualitative, participatory, and exploratory research methodology (Catalani & Minkler, 2010; Wang, 1999; Wang & Burris, 1997). These findings can be used to identify and develop appropriate strategies to reduce HIV inequities and improve the HIV care continuum. In addition, it has been suggested that photovoice participants develop new or increase existing skills, provide and receive social support, and increase their confidence in communicating with others, including those with “power,” for example, providers and policy makers (Foster-Fishman, Nowell, Deacon, Nievar, & McCann, 2005; Kieffer, 1984; Le Compte, 1995; Madrigal et al., 2014; Wang, 1999). As researchers have called for additional efforts to evaluate impacts that result from photovoice (Wang, 1999), the third aim of this study is to assess participants’ perception of, and satisfaction with, photovoice as an action-oriented research method.

Methods

Community–Academic Engagement and Partnership

Representatives from a local health department and university collaborated on and conducted this project. Discussions between the local health department and academic researchers originated after several young Black

Table 1. Discussion Prompts.

During the photo discussions	What do you see in this photo? How do you feel when you look at this photo? What do you think about this? What can we do about this?
At the community forum: large group	What do you see in these findings? In what ways do these findings make sense to you? In what ways do these findings not make sense to you?
At the community forum: small group	What can be done? What can you do? What can your agency do? What can we all do? What should we be doing down the road to address the needs and priorities of this community?

gay men met with one of the coauthors to express both their frustration with feeling ignored by the larger community and also a desire to find ways to communicate what they experience as Black MSM with HIV. As part of the State of North Carolina's HIV prevention and care funding from the CDC, the local health department had received funding to develop meaningful programming designed to increase engagement and retention in HIV care for, and with, Black MSM with HIV. However, this ongoing dialogue among community members, local health department staff, and academic researchers made it clear that the mandates of this funding were not based on the needs, assets, and priorities of local Black MSM communities. This dialogue strengthened the relationship between representatives from the community of Black MSM with HIV, health department, and university and helped identify photovoice as a viable research method to support the men in communicating their needs and priorities and taking action to address them and improve their health. Compared to traditional approaches to research, in which power is held by the academic researchers, photovoice engages directly with the participants who themselves define the content of the study (Hergenrather et al., 2009; Streng et al., 2004; Wang & Burris, 1997). Partners then applied and they were awarded funding to engage in this photovoice project.

Photovoice

Photovoice is an empowerment-based and action-oriented research method in which community members use photography and group discussion to identify and share their needs, assets, and priorities and translate findings into positive action (Wang, 1999; Wang & Burris, 1997). The goals of photovoice are to enable participants to record and reflect on their needs, assets, and priorities;

encourage critical dialogue to increase understanding about the community; and reach policy makers to improve conditions (Wang, 1999). Photovoice generally involves community members working together to (a) identify photo assignments, (b) share their photos with one another based on each photo assignment, (c) ascribe meaning through facilitated empowerment-based discussion, and (d) hold a photo exhibition and community forum to teach others about and identify actions to address their community needs, assets, and priorities (Wang, 1999; Wang & Burris, 1997).

To meet Aim 1 (describe the needs, assets, and priorities of Black MSM with HIV), participants attended one orientation session and participated in four photo discussion sessions. During the orientation session, the facilitators introduced participants to photovoice, completed informed consents, discussed how to take pictures safely and responsibly, brainstormed photo assignment topics, decided on the first photo assignment, and distributed digital cameras. Photo assignments are topics decided upon by the participants to frame the types of photographs they should be taking. During the photo discussion sessions, participants shared their photos with the other participants. The facilitators guided the photo discussion sessions using a series of prompts to encourage participants to reflect on their pictures, moving from concrete observations to abstract critical analyses and action (Hergenrather et al., 2009; see Table 1). The facilitators were a PhD-trained public health researcher who lived in the area and was committed to reducing HIV inequities and a Black MPH-trained health department employee who was implementing a project with Black MSM with HIV.

To meet Aim 2 (identify actions to improve their health), the facilitators and participants planned and hosted a photo exhibition and community forum designed to increase awareness about and to brainstorm actions to

address the needs, assets, and priorities of Black MSM with HIV. The planning process included selecting pictures and corresponding quotes from the recordings of the photo discussion sessions, writing captions, inviting individuals and organizations, and holding a practice rehearsal. Participants invited family, peer, and community members who were considered already supportive, potentially supportive, or change makers within the community. During the photo exhibition and community forum, the facilitators and participants shared the themes generated from the photo discussions and engaged the community forum attendees in reviewing the findings and identifying potential actions through empowerment-based large- and small-group discussions (see Table 1 for discussion prompts).

Measures

A short questionnaire collected sociodemographic characteristics about the participants, including age, sexual orientation, date of HIV diagnosis, most recent viral load, and treatment adherence.

To meet Aim 3 (assess impacts of photovoice), five open-ended questions that had been previously developed to assess impacts of photovoice (Haarstad, 2008) were asked to the participants after the photo exhibition and community forum were completed. These questions were used to explore what the participants liked and did not like about the photovoice project and how the photovoice project affected their lives.

Participant Recruitment

Participants were recruited through a local infectious diseases/HIV clinic. Partners met with patient navigators (i.e., clinic staff who guide patients through the health-care system and in receiving medical care) to describe the project, answer questions, and develop referral protocols. Patient navigators explained the project to patients who met the inclusion criteria (i.e., male, engaged in same-sex sexual behavior, and HIV diagnosis). Those who expressed interest completed the referral forms. Facilitators reached out to each potential participant to describe the project, answer questions, and invite them to the orientation session. The study was reviewed and approved by the Wake Forest School of Medicine Institutional Review Board.

Data Analysis

Recordings of photo discussions were analyzed using thematic analysis (Guest, MacQueen, & Namey, 2012). After each photo discussion session, the facilitators independently listened and relistened to the digital recording,

reviewed notes taken during the photo discussion sessions, recorded preliminary ideas, produced initial codes, and generated themes by collating codes. At the beginning of the following photo discussion, the facilitators presented the themes to the participants for review, refinement, and validation (i.e., member checking to improve the validity). Descriptive analyses were conducted to describe participant characteristics. Responses to the open-ended questions about photovoice impacts were analyzed using thematic analysis.

Results

Participants

The average age of the six participants was 32.3 years ($SD = 10.5$, range = 24–50). Participants used a variety of terms to describe their sexual orientation, including gay ($n = 4$, 67%), bisexual ($n = 1$, 17%), and “sexual” ($n = 1$, 17%); all reported sex with other men. On average, participants had been diagnosed with HIV for 7.5 years ($SD = 4.5$, range = 2–14). Their most recent viral load ranged from undetectable ($n = 2$, 33%) to 50,000 HIV copies per milliliter. Five (83%) of the participants reported taking medications for HIV and among these five, three (60%) reported taking all of their HIV medication the day preceding baseline data collection, and two (40%) reported taking none of it the day preceding baseline data collection.

Themes

To guide the photo discussions, participants decided upon the following four photo assignments: triggers, success, the future, and coping. From across the photo discussions, five themes were identified: discrimination and rejection, lack of mental health services, coping strategies to reduce stress, sources of acceptance and support, and future aspirations.

Discrimination and rejection. Participants described a lack of acceptance for their sexual orientation and/or their HIV status from family, friends, and acquaintances, and often these various sources of discrimination were discussed at the same time. Participants described this lack of acceptance through being rejected, being the subject of slurs and condemnation, feeling unwelcome, and being treated unfairly by employers. The following quotes exemplified these sentiments as described by many participants. For example:

It took me a long time to get over being HIV positive because there are lots of misconceptions. But there's still a constant and ongoing struggle with being Black, gay, and male. There's constant hatred towards us . . . discrimination from

my own family as well as the people I associate with at church.

Another participant shared:

My family threw me away when I first came out . . . My dad almost got violent [with me] . . . and my aunt said the next time I see you, I'll see you in a pine box. . . . You're going to die of AIDS.

And finally, "when families find out you're gay and sick, infected, ill on top of that, you face rejection."

In addition to being explicitly rejected, participants described experiences of implicit rejection through multiple sources of negative messages. One noted:

When you're dating online, on profiles you see I want someone clean but in that world that means disease free. . . . Why do you have to associate someone who is living with HIV as dirty?

Many participants described that these experiences of rejection relating to HIV have led to their experiencing feelings of anxiety and depression. For example, one participant shared:

I was going to tell [disclose HIV status] them [my cousins], but then they said if they ever found out I had it [HIV], then they couldn't be around me . . . and that hurt me so badly.

Participants concluded that such experiences made it difficult to disclose to others they were living with HIV and many had not told their family members or friends.

Lack of mental health services. All participants acknowledged improving their mental health was a priority and described experiencing feelings of anxiety and depression at multiple points throughout their lives, relating these feelings to society's response to PLWH. Participants reported great difficulties in accessing mental health services, including identifying competent providers, insurance coverage, and cost. They also stressed that access to mental health services needed to be prioritized particularly after HIV diagnosis. One participant, when reflecting on a photo of an all-black sky, described the first few years after being diagnosed as "darkness" with strong feelings of hopelessness, "thinking I was tainted, thinking that . . . I was going to die alone, that I wouldn't find any love and it would be a painful death." He also described his suicide ideation during this time as "right across from the street was the gulf and that was going to be the ticket out."

Coping strategies to reduce stress. Participants described the use of strategies as a way to break away or escape

from stress temporarily. Participants identified a variety of coping mechanisms they used, including working, reading, drinking alcohol, sleeping, eating, playing games, and creating and appreciating art. While looking at his picture of his pillow on his bed, a participant commented:

I need my rest. It's [sleep's] an escape. Let me chill out. It gives me time to take a break before addressing my stresses.

Another noted:

Reading is a way to escape reality and go somewhere different—fight dragons, do magic . . . I'm escaping the realities of my family.

During the photo discussion, another participant shared a photograph of a stained glass mosaic window he created to symbolize the cathartic power of art and the importance of art in his life. He stated:

[Creating art is] visually stimulating but physically requires me to concentrate on other things. And I wish there were more opportunities that were free that would just be another outlet for survival.

Finally, participants reported that some of these coping mechanisms provided them consolation, as illustrated in the comment:

Spam [a type of canned meat] for me is comfort, a tie to the past. Having lost every member of my immediate family, there only remain two constants, Spam and God.

Sources of acceptance and support. Participants talked about how they wanted and needed acceptance and support, both from themselves and others. One participant shared the importance of self-acceptance:

In order to have someone love you, you need to love yourself. I can't be in a good, decent relationship or even think about getting married before I learn to love and trust myself.

Participants also shared the processes and time it took to develop support for living with HIV.

A couple of years after being diagnosed I began to become educated, meeting people who lived a successful life with longevity that had a lot to offer, a productive life. That gave me hope that I could accomplish those things they were.

In addition to support for living with HIV, participants described how they developed and found acceptance and support broadly from nonfamilial sources. As described

by a participant who had taken a picture of his computer desktop:

I met a lot of good people through them [playing video games], a lot of people who understood me. I made my own family of online friends. They know everything about me; I know everything about them. They are my real family.

Future aspirations. Participants discussed how their future aspirations were driven by wanting to improve the social conditions for others. They described that focusing on career- and monetary-based definitions of success, which many held before diagnosis, were less important after diagnosis. Instead, participants concluded that as long as basic needs were covered and they could live comfortably, their new goals for success were based on their desire to overcome the experiences they had with rejection and discrimination and help others overcome them as well. The next two quotes from two participants illustrate their unique plans to meet this goal:

Having my movies and TV shows seen and having people feel better, by helping take people outside of all the negative stuff going on in this world, that makes me feel better and keeps me going too.

And,

I want to give back to adolescents with HIV . . . give them hope, even if you don't have family I can be that person in their corner . . . letting them know that all of us have survivors in us.

In addition to improving conditions for people broadly and for persons with HIV specifically, participants related success to being happy with, and appreciative of, themselves. Participants also desired familial harmony and wanted their families to be unified with them regardless of their HIV status. A participant illustrated his aspiration with the following comment:

Success for me is accepting and realizing that at the end of the day because we are family we still need to be together. In order to reach success, I need to have a foundation in self-acceptance and self-love.

Relationships with specific individuals could also be inspirational and encouraging. Some participants drew from these relationships to motivate them to take steps toward their goals:

God will bring you something this small [referring to his baby who is HIV negative] to let you know that you have the strength to live and to keep going. . . . She [the baby] got me focused. I live by myself. I support myself. I'm back in school. . . . This is my strength right here. She's my strength.

Community Forum—Identified Actions

During the photo exhibition and community forum, photographs and captions were displayed; the participants and facilitators presented the findings. Afterward, attendees engaged in discussion with participants to identify actions to improve the health of Black MSM with HIV by addressing their needs and priorities (Aim 2). Thirty-seven attendees were present, including participants' family members, lay community members, mental health providers, medical providers, faith leaders, and representatives from community-based organizations (including organizations serving the lesbian, gay, bisexual, and transgender [LGBT] community, Blacks, and people with AIDS), the local congressional district office, the local health department, academic institutions (including historically Black colleges and universities), a hospital, and an art museum. After reviewing the themes from the photo discussions and completing the empowerment-based discussions, community forum attendees and participants identified 12 actions (see Table 2).

In addition to identifying potential future actions, partnerships and networks were formed and/or strengthened between participants and attendees. Attendees shared resources and information about relevant upcoming events and created and strengthened relationships with one another and with the participants. Second, a representative from a local art museum hosted a private tour of an art exhibit and art-making workshop for the participants free of charge. Based on her experience at the forum, she thought that the museum exhibit titled "Loss & Love," which examined the power of art as a channel to process loss, would be a powerful tool to encourage self-reflection and learning. During the art-making workshop, she coached the participants through a printmaking process. Although a one-time event, she encouraged the participants to continue connecting with her and the museum.

After the photo exhibition and community forum were completed, the facilitators created a professionally bound book, which summarized the photovoice project, photo exhibition, and community forum. This book included the themes discussed, photographs shared, and community forum-identified actions. This book was developed to assist the participants in creating further program and policy change, as the book may help influential advocates and policy makers understand this community's needs, assets, and priorities and enact possible actions identified during the forum. This photovoice project book was helpful in the advocacy work of one of the participants after the project had completed.

This participant, along with one of the facilitators and a coauthor had a meeting with a local U.S. House of Representatives congresswoman whose district encompassed part of the area where this photovoice

Table 2. Actions Identified at the Community Forum.

Develop safe, nonpunitive places for conversations that are led by the people directly affected
Explore and reduce barriers to HIV testing
Work with academia, community nonprofits, and nontraditional partners (e.g., prisons, churches)
Address systemic racism in the LGBT community
Eliminate HIV and sexual orientation stigma
Have more dialogue and in a variety of venues, particularly with families
Address HIV risk factors outside of sex
Encourage holistic treatment for those who are living with HIV
Empower youth to lead and advocate
Make structural changes in the legal system and medical system
Use art as a way to express lived experiences
Exhibit the photography from today in local restaurants and venues

Note. LGBT = lesbian, gay, bisexual, and transgender.

project was implemented. At the meeting, the photovoice project book and a summary of the photo exhibition and community forum were presented and discussed. This meeting was solely initiated by the participant's invitation of his Congresswoman to the photo exhibition and community forum, as he wanted her to understand and advocate for his community's needs, assets, and priorities. Although she was unable to attend, she did send a staff member to the photo exhibition and community forum and they were able to meet afterward.

Acceptability and Impacts of Photovoice

Participants identified a variety of reasons they liked the photovoice project, including the opportunity for self-expression (e.g., "It definitely gave me a reason to voice my opinion"), the group dynamics (e.g., "I felt very comfortable with the group, and I gained great friends in the process"), and the photography (e.g., "The message/support behind the art that impacted me personally"). No participants recommended any changes to the photovoice project.

Participants were asked to describe the photovoice project. Their descriptions included global assessments ("An amazing experience" and "The best experience ever!"), while others focused on the relationships built ("I met a lot of really good people and it's worth doing because it's a support system that's much needed") and the changes they saw in themselves ("It opened up my heart, in order for me to help others who need help and encouragement"). Participants reported a variety of ways the photovoice project made a difference in their lives, including recognizing greater communication abilities ("I know that I can really express my feelings about the subject"), insights about themselves ("It's helped me realize a lot about my life and how to inspire others to live for the future"), and changes to the larger community ("I feel

like I have made a difference especially with the [community] forum we presented").

Discussion

This study described the needs, assets, and priorities of Black MSM with HIV who live in the Southern United States, identified actions to improve their health, and assessed the impacts of photovoice. The six men who participated in the project described discrimination and rejection and lack of mental health services as needs and priorities. These men also reported assets, including sources of acceptance and support and future aspirations, which motivated them to live as healthily as possible and to give back to others. During the community forum, community attendees and participants identified a wide range of potential actions to improve the health and well-being of Black MSM with HIV, ranging from activities focused at the individual level to those that call attention to larger structural issues. Finally, participants described a number of reasons why participating in the photovoice process was a positive experience, which suggests that photovoice may have a positive impact and is a highly acceptable research methodology to these participants.

Some of the findings in this study that describe aspects of the lives of PLWH are similar to other research findings. Previous research has described the importance of discrimination, difficulty disclosing, a lack of acceptance for their sexual orientation, and HIV serostatus (Jeffries et al., 2015; Rhodes et al., 2010; Teti, Conserve, Zhang, & Gerkovich, 2016). Previous research has also explored how this context negatively impacts mental health and HIV prevention, treatment, and care outcomes (Beyrer & Abdool Karim, 2013; Brooks, Etzel, Hinojos, Henry, & Perez, 2005; Hatzenbuehler, O'Cleirigh, Mayer, Mimiaga, & Safren, 2011; Mannheimer et al., 2014; Rintamaki, Davis, Skripkauskas, Bennett, & Wolf,

2006). Researchers, similar to the participants in the community forum, have also called for programs to place greater attention and focus on structural factors to address HIV (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013; DiClemente & Wingood, 2000; Sumartojo, 2000). Other actions identified during the community forum to promote HIV prevention include youth leadership and the arts; some researchers have had successes with these two strategies (Glik, Nowak, Valente, Sapsis, & Martin, 2002; Pearlman, Camberg, Wallace, Symons, & Finison, 2002), which suggests that these approaches could be further explored as they are also acceptable to communities. Finally, a body of research has described the ways HIV status is discussed in online social and sexual networking spaces and how HIV status has been used to screen potential partners and make decisions about condom use (Carballo-Diéguez, Miner, Dolezal, Rosser, & Jacoby, 2006; Grov, Hirshfield, Remien, Humberstone, & Chiasson, 2013; Mustanski, Lyons, & Garcia, 2011; Spieldenner, 2014); this study adds to the literature by explaining how Black MSM with HIV experience stigma and how those experiences may make disclosing difficult within their sexual and romantic relationships.

Based on the literature about the central role of the church and God in Black communities and the Southern United States (Lincoln & Mamiya, 1990; Miller, 2005), it is surprising that the participants did not take photos revolving around the church, yet participants did discuss the church and God during the photo discussions. For some participants, church was a setting where they experienced discrimination and rejection; for other participants, God was a crucial component of their spirituality and provided comfort. This tension reappeared when participants were deciding on whom to invite to the photo exhibition and community forum; several of the participants suggested inviting their pastors or pastors from certain churches who they knew would be supportive of them, but for others, though recognizing pastors as influential advocates, they felt hesitancy toward inviting them to the photo exhibition and community forum. This juxtaposition suggests that the church remains an important aspect of the lives of Black MSM with HIV and there are Black churches in the Southern United States that are supportive. However, there also appears to be a tension between Black MSM with HIV and the church and God. Previous research has described the homophobia, stigma, and discrimination that Black MSM have experienced at church (Harris, 2009; Miller, 2007; Valera & Taylor, 2011). These negative experiences may have made it more difficult for participants to turn to their churches for comfort and to cope. Future research should continue to explore how Black MSM with HIV integrate and reconcile these experiences.

This study also makes contributions to the literature about the impacts of photovoice. Similar to other studies, participants described the photovoice project as a highly positive experience (Foster-Fishman et al., 2005; Woolford et al., 2012). This may explain why photovoice has been successfully used to address diverse concerns and with vulnerable groups, including environmental and housing issues, chronic disease, Latino adults with intellectual disabilities, and homeless and housed youth (Baker & Wang, 2006; Castleden, Garvin, & First Nation, 2008; Catalani & Minkler, 2010; Hergenrather et al., 2009; Jurkowski & Paul-Ward, 2007; Woolford et al., 2012). It seems like a key impact of this photovoice process is the relationships formed and built through photovoice. For persons with HIV, their interpersonal relationships play a very important role in their treatment and care (Rhodes et al., 2010; Teti et al., 2016). These findings raise questions for future research to explore how photovoice results in these positive impacts.

The findings for this photovoice project should be viewed in light of its limitations. This study was carried out with a small number of participants, although it was close to the ideal size of 7–10 people for group discussions (Wang, 1999). While this study was able to develop an in-depth understanding and gain rich descriptive information about this population, it is possible that additional themes and impacts of photovoice could have been identified with more participants. It should also be recognized that this sample represents a particularly hard-to-reach population that has been disproportionately affected by HIV. In addition, this study did not have the capacity to conduct an economic analysis on photovoice. Economic evaluations are a significant component in determining implementation (Hoomans & Severens, 2014), and as such, no conclusions about the economic feasibility of photovoice can be made. Furthermore, this study was unable to demonstrate the impact of the photovoice project on program or policy change, which has been identified by others as difficult to measure (Catalani & Minkler, 2010; Wang & Pies, 2004). However, this study provided evidence from the participants of the actions they took.

Despite these limitations, this research project demonstrated the advantages of photovoice as a participatory needs assessment. First, it prioritized and focused on understanding what this community viewed as important. Second, the photographs allowed for rich description of participants' perceived needs, assets, and priorities. Third, behaviors and settings that are not easily available to researchers were recorded and described. Fourth, this process and method stimulated social action and encouraged participants to become advocates for their community's health. Of particular note is the participant who independently requested and was successful in meeting with a

state-level policy maker to share these findings. Photovoice served as a channel for a marginalized community to reach policy makers to advocate for issues that are important to them; as several of the actions identified in the community forum are policy and structural changes, having policy makers involved can accelerate shepherding legislation and policy. These meetings with constituents can make a significant difference in how policy makers think about, prioritize, and make decisions to address issues. Fifth, tangible products were created (i.e., physical printouts of the photographs and project books with the photographs and corresponding transcribed explanations), which enabled participants to continue to express themselves, build bonds, and share something of value they made themselves with important others, including friends, influential advocates, and policy makers. Finally, this study leveraged the strengths of having project and group discussion facilitators who were similar and different from the photovoice participants across gender, race, and sexual orientation; an “insider” facilitator may increase participants’ comfort and disclosure, while an “outsider” facilitator who lacks a common knowledge may be able to elicit detailed responses that may have been otherwise assumed (Rhodes, Hergenrather, Wilkin, & Jolly, 2008; Sands, Bourjolly, & Roer-Strier, 2007; Seal, Bloom, & Somlai, 2000; Tinker & Armstrong, 2008).

Conclusions

This study suggests that photovoice is a useful process for building a rich understanding of participants’ lives and factors that influence their health and well-being. Participants report feeling highly satisfied with photovoice as a process for identifying and addressing individual- and community-level needs, assets, and priorities. The actions identified during the community forum highlight the need to approach interventions on multiple levels. Photovoice, itself, may result in positive individual- and community-level changes and improve health by changing individual, interpersonal, and structural factors. Future research should continue to utilize photovoice and explore its potential impact.

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Note

1. The term “inequities” rather than “disparities” is used to describe the poor HIV-related outcomes experienced by Black MSM communities. The term “inequities” recognizes that the HIV-related health outcomes of Black MSM communities are determined by “intentional, systematic, and structural” barriers along the HIV care continuum (Bowleg, 2017).

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